HARMONY HORIZON SERVICES LLC

HCBS MEMBER REFERRAL FORM

Brain Injury (BI) Waiver - Supported Community Living | Intellectual Disability (ID) Waiver - Supported Community Living | Habilitation - Home-Based Habilitation

Referral Purpose: This form is used to help Harmony Horizon Services LLC (HHS) determine service fit, support needs, staffing requirements, health and safety considerations, and next steps for admission. Submission of a referral does not guarantee acceptance or admission.

Confidentiality Notice: This form may contain protected or confidential information. Submit only through an HHS-approved secure method. HHS will use referral information only for service coordination, screening, admission, and other permitted purposes.

1. REFERRAL INFORMATION

Referral Date: _____	Requested Start Date: _____
Referring Person: _____	Title/Role: _____
Agency/Organization: _____	Phone: _____
Email: _____	Preferred Contact Method: ☐ Phone ☐ Email

Reason for Referral / Primary Concern:

_____

_____

_____

Is this referral urgent? ☐ Yes ☐ No	If yes, desired response timeframe: _____
Current Case Manager/Care Coordinator: _____	Phone/Email: _____

☐ Iowa Total Care	☐ Molina Healthcare
☐ Wellpoint	☐ Other MCO/Payor: _____

2. MEMBER INFORMATION

Member Legal Name: _____	Preferred Name: _____
Date of Birth: _____ Age: _____	Medicaid ID #: _____
Current Address: _____	City/State/ZIP: _____
Phone: _____	Email: _____
Primary Language: _____	Interpreter Needed? ☐ Yes ☐ No

Preferred Communication Method: _____

☐ Verbal	☐ ASL
☐ AAC Device	☐ Picture/Communication Board
☐ Yes/No Buttons	☐ Gestures
☐ Other: _____	

3. LEGAL DECISION-MAKING / REPRESENTATIVE INFORMATION

☐ Member makes own decisions	☐ Full Guardianship
☐ Limited Guardianship	☐ Conservatorship
☐ Power of Attorney	☐ Other: _____

Guardian/Legal Representative Name: _____	Relationship: _____
Phone: _____	Email: _____

Are guardianship/legal documents available? ☐ Yes ☐ No ☐ N/A

_____

4. REQUESTED HCBS SERVICE

☐ Brain Injury (BI) Waiver - Supported Community Living (SCL)
☐ Intellectual Disability (ID) Waiver - Supported Community Living (SCL)
☐ Habilitation - Home-Based Habilitation (HBH)
☐ Other/Unsure: _____

Is member currently enrolled/approved? ☐ Yes ☐ No ☐ Pending	Authorization/NOD available? ☐ Yes ☐ No
Requested hours/level of support: _____	Current provider, if any: _____
New service? ☐ Yes ☐ No	Provider transfer? ☐ Yes ☐ No

Reason for changing providers / requested transition:

_____

_____

Anticipated discharge or transition date from current setting/provider: _____

_____

5. CURRENT LIVING SITUATION & RESIDENTIAL PREFERENCES

☐ Own home/apartment	☐ Family home
☐ Group home	☐ Host home
☐ Hospital	☐ Nursing facility
☐ Residential care facility	☐ Homeless/unstable housing
☐ Other: _____	

Who currently lives with the member? _____

_____

Does the member want to remain in the current residence? ☐ Yes ☐ No ☐ Unsure

_____

Is residential placement being requested? ☐ Yes ☐ No

_____

Preferred city/community: _____	Private bedroom preferred/required? ☐ Yes ☐ No
Wheelchair accessible home required? ☐ Yes ☐ No	Stairs acceptable? ☐ Yes ☐ No
Smoking status: _____	Pet allergies/concerns: _____

What is most important to the member when choosing where and with whom they live?

_____

_____

6. SUPERVISION & STAFFING NEEDS

24-hour staffing required? ☐ Yes ☐ No	1:1 staffing required? ☐ Yes ☐ No
2:1 staffing required at any time? ☐ Yes ☐ No	Protective oversight required? ☐ Yes ☐ No
Can member be left alone? ☐ Yes ☐ No ☐ Limited	If limited, maximum duration: _____
Overnight support: ☐ Awake ☐ Sleep ☐ On-call ☐ None	Line-of-sight supervision? ☐ Yes ☐ No

Describe supervision needs in the home and community, including times when the member may be alone:

_____

_____

_____

☐ Elopement/wandering concern	☐ Fall risk
☐ Community safety concern	☐ Transportation supervision
☐ Emergency response assistance	☐ Other: _____

7. MEDICAL / HEALTH INFORMATION

Primary Diagnosis: _____	Secondary Diagnosis(es): _____
Brain Injury diagnosis/date, if applicable:	Intellectual Disability diagnosis, if applicable: _____

_____	
Mental Health Diagnosis(es): _____	Primary Care Provider: _____

Significant medical conditions / health concerns:

_____

_____

☐ Seizure disorder	☐ Diabetes
☐ Mobility limitation	☐ Fall risk
☐ Swallowing/choking risk	☐ Special diet
☐ Oxygen	☐ CPAP/BiPAP
☐ Feeding tube	☐ Catheter/Ostomy
☐ Skin integrity concern	☐ Recent hospitalization/ER visit
☐ Other: _____	

Allergies (medication/food/environmental): _____

_____

Specialized medical training staff may need:

_____

_____

8. MEDICATION SUPPORT

Does member take prescribed medications? ☐ Yes ☐ No	Medication list/MAR available? ☐ Yes ☐ No
PRN medications? ☐ Yes ☐ No	Schedule II/controlled medications? ☐ Yes ☐ No
Injectable medications? ☐ Yes ☐ No	History of medication refusal? ☐ Yes ☐ No

☐ Independent self-administration	☐ Needs reminders/prompts
☐ Needs observation/supervision	☐ Needs staff administration
☐ Needs medication setup	☐ Other: _____

Medication-related concerns or special instructions:

_____

_____

9. BEHAVIORAL, EMOTIONAL & MENTAL HEALTH SUPPORTS

☐ Anxiety	☐ Depression
☐ Verbal aggression	☐ Physical aggression
☐ Property destruction	☐ Self-injurious behavior
☐ Suicidal ideation/history	☐ Elopement
☐ Pica	☐ Sexualized behavior concerns
☐ Substance use concerns	☐ Other: _____

Frequency, intensity, or recent pattern of concerns:

_____

_____

Known triggers / early warning signs:

_____

_____

Successful prevention, calming, communication, or de-escalation strategies:

_____

_____

Behavior Support Plan available? ☐ Yes ☐ No	Crisis/Safety Plan available? ☐ Yes ☐ No
Psychiatrist/Therapist involved? ☐ Yes ☐ No	Recent psychiatric hospitalization? ☐ Yes ☐ No

BI-Specific Considerations (if applicable):

☐ Memory impairment	☐ Impulsivity
☐ Executive functioning difficulty	☐ Emotional regulation difficulty

☐ Cognitive fatigue	☐ Communication changes
☐ Reduced safety awareness	☐ Other: _____

10. RIGHTS RESTRICTIONS / RESTRICTIVE INTERVENTIONS

Any current rights restrictions? ☐ Yes ☐ No	Physical restraint authorized? ☐ Yes ☐ No
Restriction documented in service plan? ☐ Yes ☐ No ☐ N/A	Member/guardian consent documented? ☐ Yes ☐ No ☐ N/A

If yes, identify each restriction and the assessed need/risk it addresses:

_____

_____

_____

Less restrictive interventions attempted and plan to reduce/eliminate restriction:

_____

_____

Date last reviewed: _____	Next quarterly review date: _____

11. ACTIVITIES OF DAILY LIVING (ADL) / FUNCTIONAL SUPPORT NEEDS

Support Area	Independent	Prompting	Partial Assist	Full Assist
Bathing	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Grooming	☐	☐	☐	☐
Toileting/Continence	☐	☐	☐	☐
Eating	☐	☐	☐	☐
Meal Preparation	☐	☐	☐	☐
Transfers	☐	☐	☐	☐
Mobility	☐	☐	☐	☐
Laundry	☐	☐	☐	☐
Housekeeping	☐	☐	☐	☐
Shopping	☐	☐	☐	☐
Money Management	☐	☐	☐	☐
Medication Management	☐	☐	☐	☐
Transportation	☐	☐	☐	☐
Appointments	☐	☐	☐	☐
Community Navigation	☐	☐	☐	☐
Phone/Communication	☐	☐	☐	☐
Emergency Response	☐	☐	☐	☐

Additional functional supports, adaptive equipment, or accessibility needs:

_____

_____

12. COMMUNICATION & SENSORY SUPPORTS

How does the member best express wants, needs, choices, discomfort, or refusal?

_____

_____

How does the member best understand information/instructions?

_____

_____

Hearing impairment? ☐ Yes ☐ No	Vision impairment? ☐ Yes ☐ No

Communication strategies that work well:

_____

_____

Communication approaches or triggers staff should avoid:

_____

_____

13. COMMUNITY INTEGRATION, INTERESTS & PERSONAL GOALS

Favorite activities, hobbies, interests, cultural/religious preferences, and important relationships:

_____

_____

_____

Employment, day program, school, volunteer, or community participation:

_____

_____

What would a good life look like to the member?

_____

_____

What does the member want HHS to help them become more independent with?

_____

_____

Current goals HHS would be expected to support:

_____

_____

14. SAFETY / RISK INFORMATION

☐ Fall risk	☐ Choking risk
☐ Fire-setting history	☐ Elopement/missing-person history
☐ Aggression	☐ Self-harm
☐ Suicide risk	☐ Exploitation vulnerability
☐ Financial exploitation concern	☐ Substance-use risk
☐ Weapons access	☐ Unsafe community behavior
☐ Emergency evacuation assistance	☐ Other: _____

Describe any known risks HHS should understand before determining whether it can safely meet the member's needs:

_____

_____

_____

15. CURRENT PROVIDERS & NATURAL SUPPORTS

Case Manager/Care Coordinator	Name/Agency/Contact: _____
Primary Care Provider	Name/Contact: _____
Psychiatrist	Name/Contact: _____
Therapist/Counselor	Name/Contact: _____
Behavioral Specialist	Name/Contact: _____
Day/Employment Provider	Name/Contact: _____
Home Health/Nursing	Name/Contact: _____
PT/OT/Speech	Name/Contact: _____
Family/Natural Supports	Name/Relationship/Contact: _____

16. DOCUMENTS REQUESTED WITH REFERRAL

☐ Current Person-Centered Service Plan / ISP	☐ Notice of Decision / Service Authorization
☐ Medicaid eligibility / MCO information	☐ Current assessment
☐ Social history	☐ Medication list / MAR
☐ Medical diagnoses / relevant health records	☐ Behavior Support Plan
☐ Crisis / Safety Plan	☐ Rights restriction documentation
☐ Guardianship / legal representative documents	☐ Release of Information

☐ Recent incident reports, if relevant	☐ Recent discharge summary
☐ Psychological evaluation	☐ Nursing assessment
☐ Risk assessment	☐ Other: _____

Additional records or information being submitted:

_____

_____

17. REFERRER ATTESTATION

To the best of my knowledge, the information provided in this referral is accurate and complete. I understand that HHS may request additional records or clarification before determining whether it can safely and appropriately meet the member's needs.

Referrer Name: _____	Title: _____
Signature: _____	Date: _____

HHS INTERNAL REFERRAL REVIEW / DISPOSITION

For Harmony Horizon Services LLC use only

A. INITIAL REVIEW

Date referral received: _____	Reviewed by: _____
Program requested: _____	MCO/Payor: _____

☐ Appears appropriate for further review	☐ Additional information required
☐ Unable to meet identified needs	☐ Waitlist consideration

Initial reviewer comments:

_____
_____
_____

B. RECORDS / VERIFICATION

☐ Service authorization verified	☐ Waiver/Habilitation enrollment verified
☐ MCO contract/coverage verified	☐ Guardian/legal authority verified
☐ Current service plan received	☐ Medication information received
☐ Behavior/crisis plans received, if applicable	☐ Rights restriction documentation received, if applicable
☐ Staffing level assessed	☐ Home/environment needs assessed

Outstanding information needed:

_____
_____

C. PRE-ADMISSION REVIEW

Intake scheduled? ☐ Yes ☐ No	Date: _____
Home visit scheduled? ☐ Yes ☐ No	Date: _____
Staffing assessment completed? ☐ Yes ☐ No	Clinical/Program review completed? ☐ Yes ☐ No

Primary service needs identified:

_____
_____
_____

Primary risks / barriers to admission identified:

_____
_____

Training or staffing requirements before admission:

_____
_____

D. REFERRAL DISPOSITION

☐ Accepted	☐ Accepted pending additional requirements
☐ Waitlisted	☐ Declined - unable to safely meet needs
☐ Declined - service/funding not authorized	☐ Referred to another provider/resource

Reason / conditions / follow-up required:

_____
_____
_____

Proposed Admission Date: _____	Assigned Supervisor/Program Manager: _____
Final Decision By: _____	Decision Date: _____

E. FINAL APPROVAL

Program Director/Administrator Signature: _____	Date: _____
Member/Guardian notified of disposition? ☐ Yes ☐ No	Date notified: _____
Case Manager/Referrer notified? ☐ Yes ☐ No	Date notified: _____